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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

89793

## 9895 CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		MARYLAND		STATE Maryland		COUNTY Harford	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Aberdeen Rural		3 1/2 yrs.		TOWN Aberdeen Rural		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Luda (Middle) (Last) Adams				(Month) (Day) (Year)			
				Oct. 10 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	Sept. 12, 1890	65 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farm tenant		Farm		Absher N.C.		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph Adams				Susan Armes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		212-16-4295		Barbara Mittson, Aberdeen Md.			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A)				Cerebral hemorrhage		24 hrs	
ANTECEDENT CAUSE(S) DUE TO				Cardiovascular		3 mos	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO				Atherosclerosis		4 yrs	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 1953, to Oct 12, 1955, that I last saw the deceased alive on Oct 11, 1955, and that death occurred at 5:00 P.M. from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
H. J. [Signature]				Narlington Md		10/13/55	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 15, 1955		Conowingo Baptist		Conowingo Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Oct. 13 '55		Bertha B. Knight		J. Earl Tyson, Rising Sun, Md.			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. CAUSE OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESS		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF CLERK		15. SIGNATURE OF JURY	

RECEIVED

BUREAU V. S.  
OCT 19 1955

RECEIVED

1

## INSTRUCTIONS

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VS 15C-1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09794

9785

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HAVER DE GRACE</u>		<u>14 DAYS</u>		TOWN <u>CARDIFF</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL HOSP.</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>MARY</u> (First) <u>BARNETT</u> (Middle) <u>BEATTIE</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>October</u> (Day) <u>18</u> (Year) <u>1955</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JAN. 25, 1870</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN BARNETT</u>				14. MOTHER'S MAIDEN NAME <u>SUE MILLIGAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____		17. INFORMANT & ADDRESS <u>MRS. MALCOLM SNOODGRASS, MDI. BELAIR</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>18 Hours</u>	
IMMEDIATE CAUSE (A) <u>Respiratory failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized carcinomatosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Biliary tract carcinoma</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>10-12-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>generalized carcinomatosis</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>10-12-55</u> to <u>10-18-55</u> , that I last saw the deceased alive on <u>10-17-55</u> , and that death occurred at <u>3:15</u> M. from the causes and on the date stated above.							
SIGNATURE <u>James M.C. Finney</u>				ADDRESS (Street, city, town, state) <u>330 B. Union Ave. Haver de Grace, Md. 21875</u>			
DATE <u>Oct. 20-55</u>				DATE SIGNED <u>John H. Harkins, Delton, Pa.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>10-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>SLATE RIDGE</u>		LOCATION (City, town, or county) <u>DELTA PA.</u>	
24. REC'D BY REGISTRAR _____		REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins</u>		ADDRESS <u>Delton, Pa.</u>	

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# CERTIFICATE OF DEATH

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BUREAU V. 2

OCT 24 1955

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9786

09795

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Harford County</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Laurel Grace</u>				CITY (If outside corporate limits write RURAL and give nearest town) <u>Street Rural</u> X			
TOWN <u>Laurel Grace</u>				TOWN <u>Street Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hosp</u>				STREET ADDRESS (If rural, give location) <u>Rt. #1 near Hill Top 7 miles</u>			
3. NAME OF DECEASED: (First) <u>Willard</u> (Middle) <u>Blevins</u> (Last) <u>Blevins</u>				4. DATE OF DEATH (Month) <u>10</u> (Day) <u>15</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>May 2 - 1921</u>	
9. AGE last birthday: <u>34</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Truck Driver</u>		11. BIRTHPLACE (State or foreign country): <u>Ashe County North Carolina</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Oscar Blevins</u>				14. MOTHER'S MAIDEN NAME: <u>M. Mattie Wyatt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>War II</u>				16. SOCIAL SECURITY No.: <u>—</u>			
17. INFORMANT & ADDRESS: <u>Wm Finley Box 787 Aberdeen Md.</u>				18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
420.1 Immediate cause (a) <u>Coronary occlusion</u> DUE TO							
Antecedent cause(s) (b) <u>—</u> DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>—</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>William V. [Signature]</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10-16-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>10/18/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Barstons Cemetery</u>		LOCATION (City, town, or county) (State): <u>White Top, Grayson Co. Va.</u>	
DATE REC'D BY LOCAL REG. <u>Oct 17-55</u>		REGISTRAR'S SIGNATURE <u>H. L. Lewis</u>		24. FUNERAL DIRECTOR <u>John G. Tarrington Aberdeen Md.</u>		ADDRESS	

10/19/55

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MEMORANDUM FOR THE DIRECTOR, FBI  
SUBJECT: [Illegible]

[The body of the memorandum contains several paragraphs of extremely faint, illegible text.]

RECEIVED  
OCT 20 1955  
FBI

RECEIVED  
OCT 19 1955  
BUREAU A. S.



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INSTRUCTIONS

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VS A15 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09796

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## CERTIFICATE OF DEATH

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Sandy Hook Rd.</u>		<u>8 mo</u>		TOWN <u>Sandy Hook Road</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Michael</u> (Middle) <u>Thomas</u> (Last) <u>Boggs</u>				(Month) <u>Oct</u> (Day) <u>11</u> (Year) <u>55</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>M</u>	<u>W</u>	<u>Single</u>	<u>AUG 9 1945</u>	<u>10</u> yrs.	Months <u>1</u>	Days <u>3</u>	Hours <u></u> Min. <u></u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>School Boy</u>		<u>-</u>		<u>Balts City</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Simon J Boggs</u>				<u>Ruth MATH</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
<u>-</u>				<u>-</u>		<u>Simon J. Boggs Street Rd. Md.</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>15. MEDICAL CERTIFICATION</b>	
<b>IMMEDIATE CAUSE</b> (A) <u>HODGKINS DISEASE</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>						<u>23 months</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (B) <u>-</u>							
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> (C) <u>-</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21a. INJURY OCCURRED</b> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Nov. 1953, to Oct. 11, 1955, that I last saw the deceased alive on Oct. 6, 1955, and that death occurred at 2:30 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Willard P. Hudson</u>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
				<u>M.D. Forest Hill, Md.</u>		<u>10-11-55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>Oct 13-55</u>		<u>Bel Air Memorial Gardens</u>		<u>Bel Air Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>16-14-55</u>		<u>Priscilla Lowndes</u>		<u>Willard P. Hudson</u>		<u>Forest Hill, Md.</u>	

# CERTIFICATE OF DEATH

Hartford

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Record / Oct 13-22 Bel/cir men partners  
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INSTRUCTIONS

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9737

## CERTIFICATE OF DEATH

09797

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Lanvale Grace</u>				TOWN <u>Bel Air, Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>Rt. #1, Box 374</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>John Foy Carico</u>				<u>October 11</u> 19 <u>55</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>Male</u>	<u>White</u>		<u>8/29/1876</u>	<u>79</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Farmer</u>		<u>Farm Self Emp.</u>		<u>Virginia</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Creed M. Carico</u>				<u>Emaline Spuler</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
<u>No</u>				<u>None</u>		<u>Claude F. Carico Bel Air, Md.</u>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A) <u>420.1 Coronary Occlusion</u>						<u>Sudden</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Artery Disease</u>						<u>2</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Generalized Arterio-sclerosis</u>						<u>-</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>May 1</u>, 19<u>52</u>, to <u>Oct 11</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Oct 11</u>, 19<u>55</u>, and that death occurred at <u>3:19 PM</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
<u>Willard P. Heedson M.D.</u>				<u>Forest Hill</u>		<u>11/11/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b> (State)	
<u>Burial</u>		<u>10/14/55</u>		<u>Bel Air Memorial Gardens</u>		<u>Bel Air Harford Co. Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>Oct 14 - 1955</u>		<u>A. L. Lewis M.D.</u>		<u>John G. Barrington</u>		<u>Bel Air, Md.</u>	

10703

WESTERN STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

# DEATH CERTIFICATE

1. Name of deceased (Print or write full name)

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Date of death

7. Cause of death

8. Place of death

9. Signature of physician

10. Signature of registrar

11. Signature of informant

12. Signature of witness

13. Signature of undertaker

14. Signature of funeral home

15. Signature of cemetery

16. Signature of church

17. Signature of school

18. Signature of employer

19. Signature of neighbor

20. Signature of friend

21. Signature of relative

22. Signature of community

23. Signature of society

24. Signature of association

25. Signature of organization

26. Signature of institution

27. Signature of establishment

28. Signature of enterprise

29. Signature of concern

30. Signature of business

31. Signature of industry

32. Signature of profession

33. Signature of occupation

34. Signature of trade

35. Signature of service

36. Signature of labor

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40. Signature of deed

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9738

## CERTIFICATE OF DEATH

09798

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARTFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARTFORD</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Bel Air</u>		<u>21 yrs</u>		TOWN <u>Bel Air</u>		<u>32</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>				<u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Malala U. Chambers</u>				<u>Oct 1 1955</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>F</u>		<u>Cr</u>		<u>Single</u>		<u>Sept 13-1873</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.		yrs. Months Days	
<u>87</u>		<u>1</u>		<u>19</u>		<u>55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Housewife</u>				<u></u>		<u>Hartford Co MD</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
<u>US</u>				<u>John W. Chambers</u>			
14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, for UNK.)			
<u>Alice Collins</u>				<u>No</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS			
<u></u>				<u>Alice Chambers Bel Air MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
42. IMMEDIATE CAUSE (A)				<u>Anterior lentis CV disease</u>			
ANTECEDENT CAUSE(S) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>6 mo.</u>			
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<u></u>				<u></u>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<u></u>		<u></u>		<u></u>		<u></u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
<u></u>		<u></u>		<u></u>			
22. I hereby certify that I attended the deceased from <u>May 15 1955</u> to <u>Oct 1 1955</u> , that I last saw the deceased alive on <u>Sept 30 1955</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Harold C Palmer</u>				<u>Baltimore, Md</u>		<u>10/2/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/4/55</u>		<u>Catholics Chapel</u>		<u>Bel Air Hartf Co MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
<u></u>		<u>Priscilla Lowndes</u>		<u>Joseph T. Jester Bel Air MD</u>			
DATE <u>10-3-55</u>							

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 115C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09799

## 9789 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARTFORD</u>		STATE <u>MD</u>		COUNTY <u>Hartford</u>			
CITY OR TOWN <u>BEL AIR</u>		LENGTH OF STAY (in this place) <u>25 years</u>		CITY OR TOWN <u>BEL AIR MD</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>309 Thomas St</u>		(If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>HARRY (HARRY) CHILIMIDOS (Middle) Childs</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 22 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1893</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 Year		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Restaurant Business</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>Greece</u>	
13. FATHER'S NAME <u>Andrew Chilimidos</u>				14. MOTHER'S MAIDEN NAME <u>Agatha Mitakis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT & ADDRESS <u>Mrs. Harry Childs 309 Thomas St BEL AIR MD</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>None</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1, 1940</u> , to <u>Oct 22, 1955</u> , that I last saw the deceased alive on <u>Oct 10, 1955</u> , and that death occurred at <u>4A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Lowell C Palmer MD</u>				ADDRESS (Street, city, town, state) <u>BEL AIR MD</u>			
DATE <u>10-24-55</u>				DATE SIGNED <u>10/22/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Oct 25/55</u>		NAME OF CEMETERY OR CREMATORY <u>Creek Orthodox</u>		LOCATION (City, town, or county) (State) <u>Baltimore MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J Foster</u>		ADDRESS <u>BEL AIR MD</u>	





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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9790

## CERTIFICATE OF DEATH

09800

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Hanford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Harrodsburg</u>		<u>4 hrs.</u>		TOWN <u>Harrodsburg</u>		<u>24</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harrodsburg Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>Lincoln St. S.W.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Leslie</u> (First) <u>Daniel</u> (Middle) <u>Daniel</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>10</u> (Day) <u>3</u> (Year) <u>1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>6/29/54</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u>3</u> Min. <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>Harrodsburg N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr. M. Daniel</u>				14. MOTHER'S MAIDEN NAME <u>Kelley P. High</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>				16. SOCIAL SECURITY NO. <u>not known</u>		17. INFORMANT & ADDRESS <u>Mr. Mary G. Smith, Harrodsburg</u>	
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Acute Coronary thrombosis with myo-</u>							
ANTECEDENT CAUSE(S) DUE TO <u>Cardiac infarction and Cardiac de-</u>						<u>1 day.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>Compensation</u>							
STATING UNDERLYING CAUSE LAST, DUE TO <u>Arteriosclerotic Cardiovascular disease</u>						<u>unknown.</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. A. M. P.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 3rd</u> , 19 <u>55</u> , to <u>Oct 3rd</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 3rd</u> , 19 <u>55</u> , and that death occurred at <u>7:12 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>M.D. 420 N. Union Ave. Harrodsburg Ind. 10/4/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/7/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mary</u>		LOCATION (City, town, or county) (State) <u>Richmond, Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Oct. 5-1955</u>		<u>U. L. Lewis M.D.</u>		<u>[Signature]</u>		<u>[Address]</u>	



## 9897 CERTIFICATE OF DEATH

Reg. Dist. No. 18.1

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MT ABERDEEN</u> LENGTH OF STAY (In this place) <u>7 years</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MT ABERDEEN</u> STREET ADDRESS (If rural give location) <u>Long Bar Harbour</u>	
3. NAME OF DECEASED (Type or Print) <u>MAGDALENA</u> (First) <u>DINKA</u> (Middle) <u>DINKA</u> (Last)		4. DATE OF DEATH (Month) <u>Oct</u> (Day) <u>30</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 24, 1896</u>
9. AGE last birthday <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>10</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>CZECHOSLOVAKIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>MICHAEL Maphiea</u>		14. MOTHER'S MAIDEN NAME <u>ROSE (Do-Not-Know)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-10-4483</u>	
17. INFORMANT & ADDRESS <u>John Vinka Sr Long Bar Harbor, Harford Co. Md.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 1-5X IMMEDIATE CAUSE (A) <u>CARCINOMA of GALL-BLADDER</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>GENERALIZED METASTASES</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
19. DATE OF OPERATION <u>Oct 10, 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Ca Gall-bladder + Meta-Trans</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>July 4, 1955</u> , to <u>Oct 30, 1955</u> , that I last saw the deceased alive on <u>Oct 29, 1955</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.	
SIGNATURE <u>A. Soudeekhi M.D.</u> M.D.		ADDRESS (Street, city, town, state) <u>Bel Air, Md</u> DATE SIGNED <u>10.30.1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>Nov 1-1955</u> NAME OF CEMETERY OR CREMATORY <u>Everest Cemetery</u> LOCATION (City, town, or county) (State) <u>Indicott, New York</u>	
24. REC'D BY REGISTRAR <u>Nov. 1-1955</u> REGISTRAR'S SIGNATURE <u>Willie R. Perry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Tarrington</u> ADDRESS <u>Aberdeen Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.





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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9791

## CERTIFICATE OF DEATH

09802

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>			
CITY OR TOWN <u>House of Grace</u>		LENGTH OF STAY <u>5 days</u>		CITY OR TOWN <u>Perry Point</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Mem. Hospital</u>				STREET ADDRESS <u>Box 702</u>			
3. NAME OF DECEASED (Type or Print) <u>Ernest Roosevelt Dishman</u>				4. DATE OF DEATH (Month) <u>October</u> (Day) <u>25</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>June 1, 1912</u>	9. AGE last birthday <u>43</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. V. Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>David Dishman</u>				14. MOTHER'S MAIDEN NAME <u>Lena McCabe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>470-01-8499</u>		17. INFORMANT & ADDRESS <u>Bessie A. Dishman, Perry Point, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420-1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-22</u> , 19 <u>55</u> , to <u>10-25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-22</u> , 19 <u>55</u> , and that death occurred at <u>9:15 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>A. L. Lewis M.D.</u>				ADDRESS (Street, city, town, state) <u>Harford to Street Md.</u>		DATE SIGNED <u>10-25-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-28-55</u>		NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		LOCATION (City, town, or county) (State) <u>Bladensburg Rd., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wesley Patterson &amp; Son, Perryville, Md.</u>		ADDRESS	
DATE <u>Oct. 27-1955</u>							

100-1000

100-1000

100-1000

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100-1000

9792

## CERTIFICATE OF DEATH

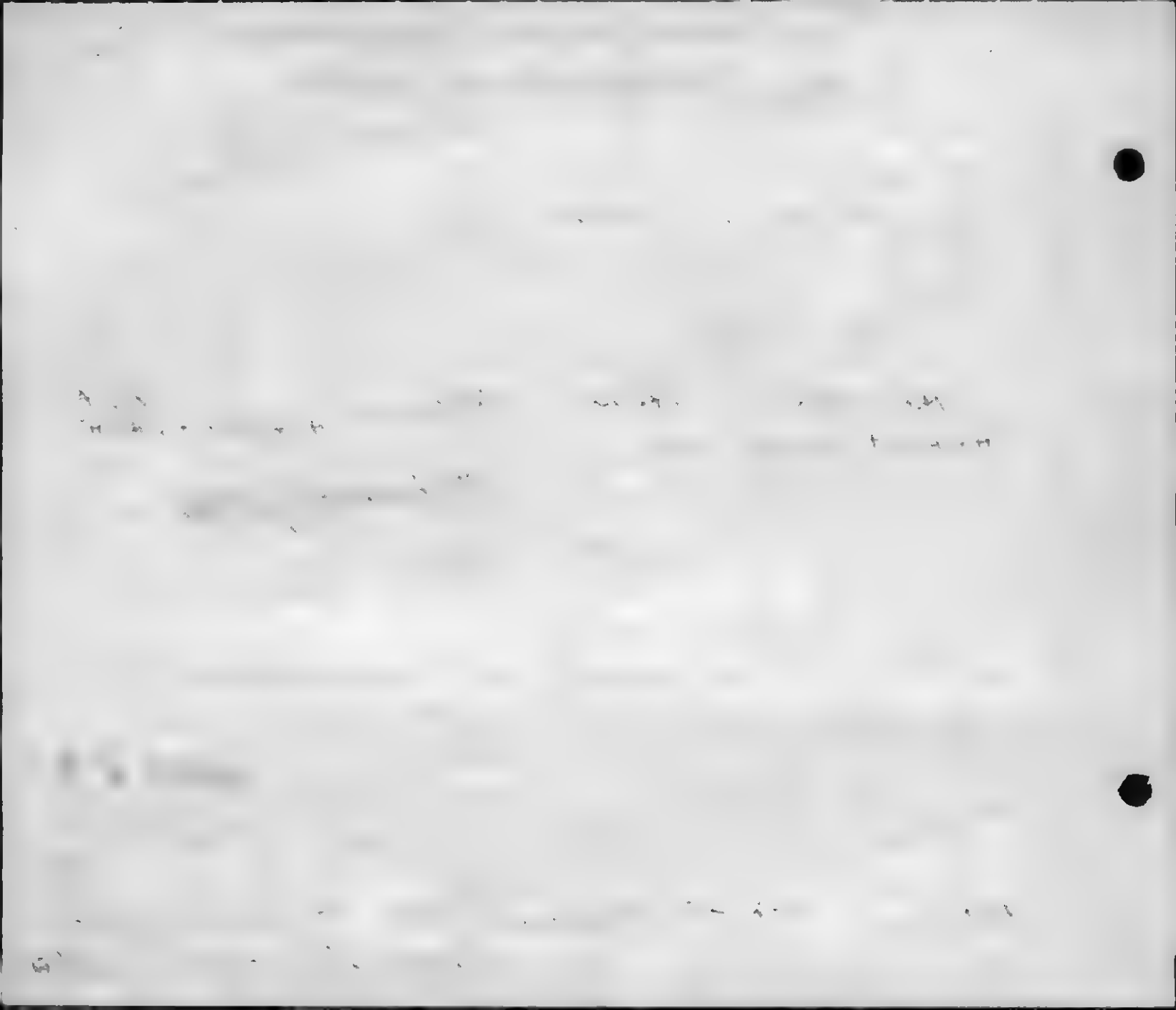
Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
24 TOWN <u>Harrods Grace</u>		10 DAYS		CITY OR TOWN <u>Annapolis</u>		02X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
71 <u>Hartford Memorial Hospital</u>				<u>R.D. # 2</u>		✓	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Frances</u> (Middle) <u>Sophia</u> (Last) <u>Dorring</u>				(Month) (Day) (Year)			
				<u>October 18, 1955</u>			
5 SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>Caucas</u>		<u>7/15/1873</u>	<u>82</u> yrs.	Months	Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House Wife</u>		<u>None</u>		<u>MD</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>CHARLES H. PITCOCK</u>				<u>ARBELLA LEIGHT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mr. Franklyn O. Dorring</u>			
				<u>Annapolis MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
432.1 IMMEDIATE CAUSE (A) <u>Cerebral embolism</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial infarction</u>				<u>few minutes</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Coronary occlusion etc</u>				<u>5 days</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis -</u>				<u>5 days</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (F EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 18, 1955</u> , to <u>Oct 18, 1955</u> , that I last saw the deceased alive on <u>Oct 18, 1955</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Franklin O. Dorring</u>				DATE SIGNED <u>Oct 18, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>10-21-55</u>		<u>Mountain Ch. Yard.</u>		<u>Hartford Co.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>G. L. Lewis M.D.</u>		<u>R. Madison Mitchell</u>		<u>Harrods Grace MD.</u>	
DATE <u>Oct 20-55</u>							

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9793

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09804  
Reg. Dist.

No. 185

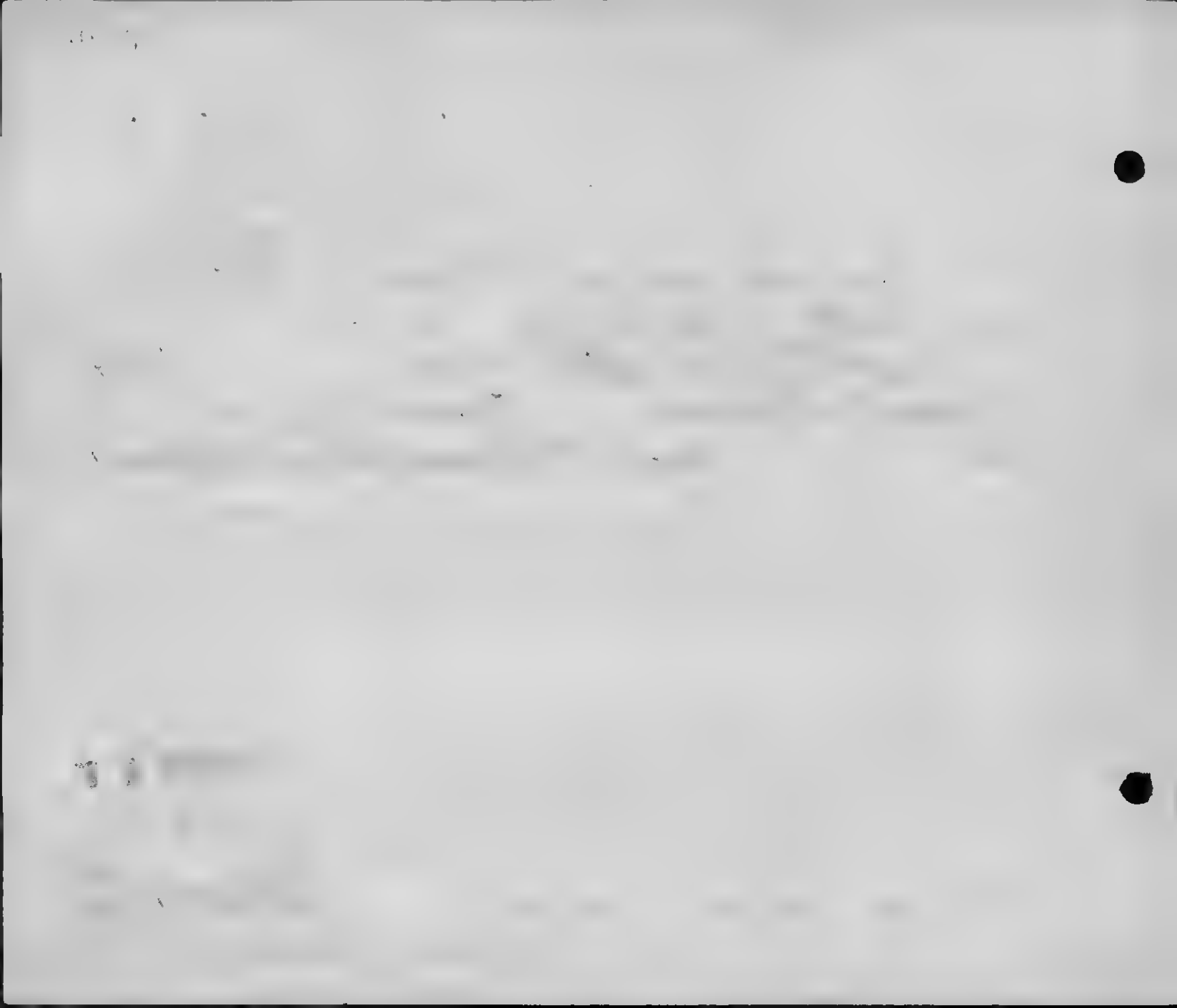
<b>1. PLACE OF DEATH:</b> COUNTY <u>Harford</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Harrods Grace</u> TOWN <u>Harrods Grace</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>201 Harford Memorial Hospital</u>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> STATE <u>Md</u> COUNTY <u>Cecil</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Port Deposit</u> OR TOWN <u>Port Deposit</u> STREET ADDRESS (If rural, give location) <u>73 North Main</u>	
<b>3. NAME OF DECEASED:</b> (Type or Print) (First) (Middle) (Last) <u>Joseph Rowlings Gibson</u>		<b>4. DATE OF DEATH:</b> (Month) (Day) (Year) <u>Oct. 4 1953</u>	
<b>5. SEX:</b> <u>Male</u>	<b>6. COLOR OR RACE:</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH:</b> <u>July 11, 1911</u>
<b>9. AGE last birthday:</b> If UNDER 1 YEAR: Months Days Hours Min. <u>44</u> yrs.		<b>10. BIRTHPLACE (State or foreign country):</b> <u>Md</u>	
<b>11. USUAL OCCUPATION (Give kind of work done during most of life, even if seasonal):</b> <u>Gen. Store</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME:</b> <u>James W. Gibson</u>		<b>14. MOTHER'S MAIDEN NAME:</b> <u>Ressie E. French</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY No.:</b> <u>210-07-1782</u>	
<b>17. INFORMANT &amp; ADDRESS:</b> <u>Flora Gibson, Port Deposit, Md</u>			

<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b> Immediate cause (a) <u>Fracture skull</u> DUE TO Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) _____		<b>INTERVAL BETWEEN ONSET AND DEATH</b> _____
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<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH:</b> <u>Fracture of femur</u>		<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>19a. DATE OF OPERATION:</b>	<b>19b. MAJOR FINDING OF OPERATION:</b>	<b>21. HOW DID INJURY OCCUR?</b> <u>Auto accident, auto - auto type</u>
<b>21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH:</b> <input type="checkbox"/>	<b>21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:</b> <u>Swanwick Bridge Route 40 Perryville, Cecil</u>	<b>21c. (City or town) (County) (State):</b> <u>Perryville, Cecil Md.</u>
<b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY:</b> <u>10/4/55 12:40 A.M.</u>	<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>	

<b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>			
<b>SIGNATURE</b> <u>Gerald C Palmer</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAM.</b> <input checked="" type="checkbox"/> <u>10/4/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify):</b> <u>Burial</u>	<b>DATE THEREOF</b> <u>Oct 7 1955</u>	<b>NAME OF CEMETERY, OR CREMATORY</b> <u>Holmwood</u>	<b>LOCATION (City, town, or county) (State)</b> <u>Port Deposit, Md</u>
<b>DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE</b> <u>Oct 5 - 1955</u>		<b>24. FUNERAL DIRECTOR</b> <u>Lee J. Patterson, Perryville, Md.</u>	





9878

## CERTIFICATE OF DEATH

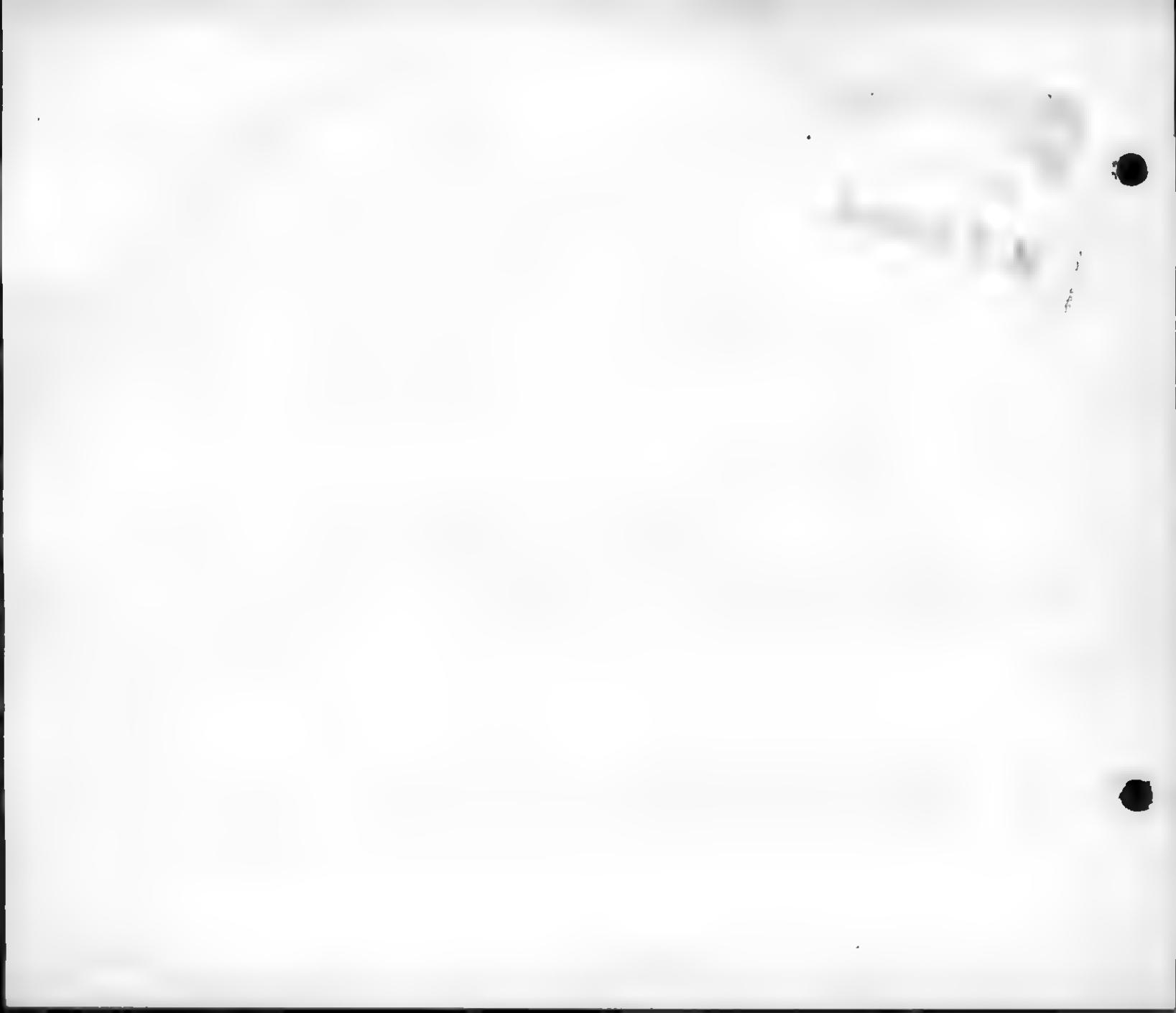
Reg. Dist. No. 182

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL - STREET</u>			
X TOWN <u>RURAL - STREET</u>		<u>71</u> yrs.		STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>OCT. 20, 1955</u>			
<u>CHARLES AUGUSTINE GLACKIN</u>							
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>AUG. 20, 1884</u>	9. AGE last birthday: <u>71</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>FARMER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>AGRI.</u>		11. BIRTHPLACE (State or foreign country): <u>HARFORD CO., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>CHARLES R. GLACKIN</u>				14. MOTHER'S MAIDEN NAME: <u>CAROLINE R. SWEENEY</u>			
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, No or unk.) (If Yes, give war or dates of service): <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>MRS. MAHALA GLACKIN, STREET, MD.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CARCINOMA of the Head of PANCREAS</u>				<u>1 yr</u>			
ANTECEDENT CAUSE (B) <u>PANCREAS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>July 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of the Head of pancreas</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 23, 1955</u> , to <u>OCT 20, 1955</u> , that I last saw the deceased alive on <u>OCT 20, 1955</u> , and that death occurred at <u>12/5 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Malcolm Dudley Phillips</u>				ADDRESS <u>Delmar, Md</u>		DATE SIGNED <u>10/23/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>10-24-55</u>		NAME OF CEMETERY OR CREMATORY <u>ST. MARYS</u>		LOCATION (City, town, or county) (State) <u>PLESVILLE, MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-23-55</u>		REGISTRAR'S SIGNATURE <u>Patricia Foxwood</u>		24. FUNERAL DIRECTOR <u>JOHN H. HARKINS, DELTA, PA.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09806

9809

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Pulnam Road</u>		<u>45 yrs</u>		TOWN <u>Pulnam Road</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
<u>—</u>				<u>Forest Hill Rd</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>William Stanley Gover</u>				<u>Oct 23 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>cc</u>	<u>married</u>	<u>Feb 24 1890</u>	<u>65</u> yrs.	Months	Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>general</u>		<u>Madonna md</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George Gover</u>				<u>Martha A. Hall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>207-63-6076</u>		<u>Edna A. Gover Forest Hill Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				15. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<u>422.1</u>				<u>20 min. (approx)</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C) <u>Chronic cardio-vascular disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>None</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1954</u> to <u>October 1955</u> , that I last saw the deceased alive on <u>Oct. 15, 1955</u> , and that death occurred at <u>8:15 a.m.</u> from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Willard P. Hudson M.D.</u>				<u>October 25, 1955</u>			
ADDRESS (Street, city, town, or county)							
<u>Forest Hill, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)			
<u>Burial</u>	<u>Oct 26 1955</u>	<u>Fairview</u>		<u>Forest Hill, Harford, Md</u>			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE			25. FUNERAL DIRECTOR'S SIGNATURE			
<u>10-29-56</u>	<u>Priscilla Howard</u>			<u>Martha E. G. Janette</u>			
DATE				ADDRESS			
				<u>md</u>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

Harford

Platinum Road, Harford

Harford

Platinum Road

Forest Hill, Md.

Oct 22, 1911

Male 60

Former

Edgar J. Foster

Mr

Harford, Md. 1911

General Washington and

Harford, Md.

217-23-6644 (Harford, Md.)

Harford

Oct 22, 1911

Forest Hill, Md.

Harford, Md.



9810

## CERTIFICATE OF DEATH

Reg. Dist. No. 180

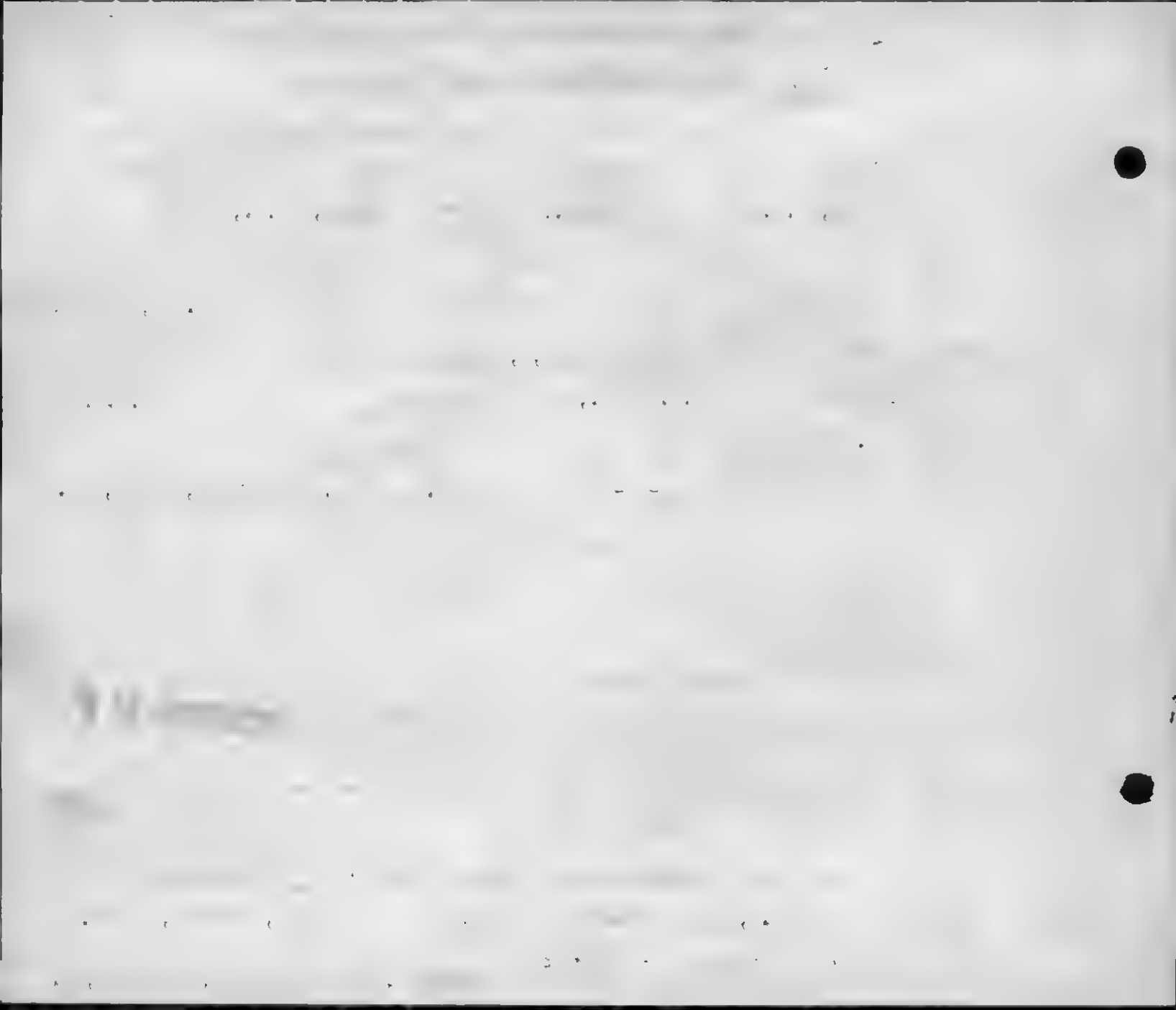
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Harford</b>		STATE <b>Maryland</b>		COUNTY <b>Harford</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Joppa, R.D.</b>		<b>26 yrs.,</b>		TOWN <b>Joppa, R.D.,</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) <b>Samuel</b> (Middle) <b>Slater</b> (Last) <b>Greenfield</b>				DEATH <b>Oct. 2,</b> 19 <b>55</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>male</b>	<b>white</b>	<b>married</b>	<b>May 8, 1893</b>	<b>62</b> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Stock Clerk</b>		<b>U.S. Govt.,</b>		<b>Maryland</b>		<b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>Samuel B. Greenfield</b>				<b>Wilanna Black</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>no</b>		<b>218-03-0888</b>		<b>Mrs. Pearl E. Greenfield, Joppa, Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
782.4 IMMEDIATE CAUSE (A) <b>Acute cardio resp. failure</b>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Myocardial infarction.</b>						<b>immediate</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						<b>2 years.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Howard K. McCombs</b>				ADDRESS (Street, city, town, state) <b>Howard K. McCombs &amp; Son, Abingdon, Md.</b>			
DATE <b>Oct 4, 1955</b>				DATE SIGNED <b>Oct 3, 1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)			
<b>Burial</b>		<b>Oct. 5, 1955</b>		<b>Mountain Christian Joppa, Harford, Md.</b>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
		<b>Norma G. Moore</b>		<b>Howard K. McCombs &amp; Son</b>			
DATE <b>Oct 4, 1955</b>							

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



9811

## CERTIFICATE OF DEATH

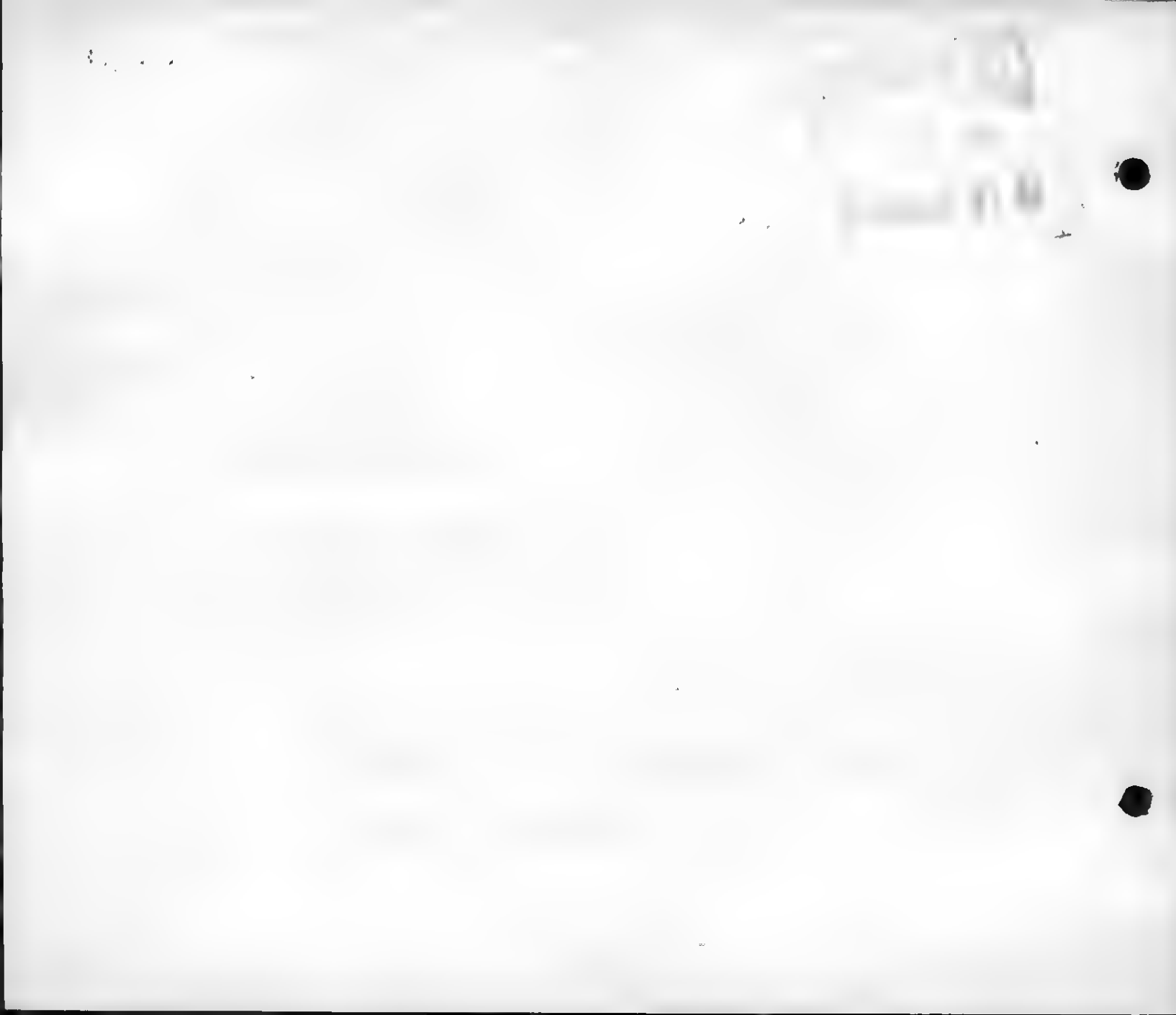
Reg. Dist. No. 182

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>HARFORD</b>		MARYLAND		STATE <b>MD.</b>		COUNTY <b>HARFORD</b>	
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X <b>WHITEFORD</b>		<b>66 yrs.</b>		<b>WHITEFORD</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
<b>DAVID ELWOOD HUGHES</b>				<b>Oct. 29 1955</b>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<b>M</b>	<b>W</b>	<b>MARRIED</b>	<b>MAY 18, 1989</b>	<b>66 yrs.</b>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<b>SLATE CUTTER</b>		<b>SLATE</b>		<b>WHITEFORD, MD.</b>		<b>U.S.A.</b>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>THOMAS HUGHES</b>				<b>JULIA MORRISON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<b>No</b>		<b>185-09-9769</b>		<b>Mrs. KATHAYN HUGHES, WHITEFORD</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE		(A) DUE TO		<b>Carcinoma of larynx</b>		<b>2 yrs.</b>	
ANTECEDENT CAUSE (B)		(B) DUE TO		<b>with metastasis.</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>Nov. 1953</b>		<b>Carcinoma of larynx</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Aug. 28, 1949</b> , to <b>Oct. 20, 1955</b> , that I last saw the deceased alive on <b>Oct. 20</b> , 1955, and that death occurred at <b>11:15 AM</b> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<b>Charles E. Neff MD</b>		<b>Street, Md.</b>		<b>Oct 22, 1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>10-24-55</b>		<b>EMORY</b>		<b>STREET, MD.</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>10-23-55</b>		<b>Phyllis Woodward</b>		<b>JOHN H. HARKINS, DELTA, PA.</b>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



09809

9794

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

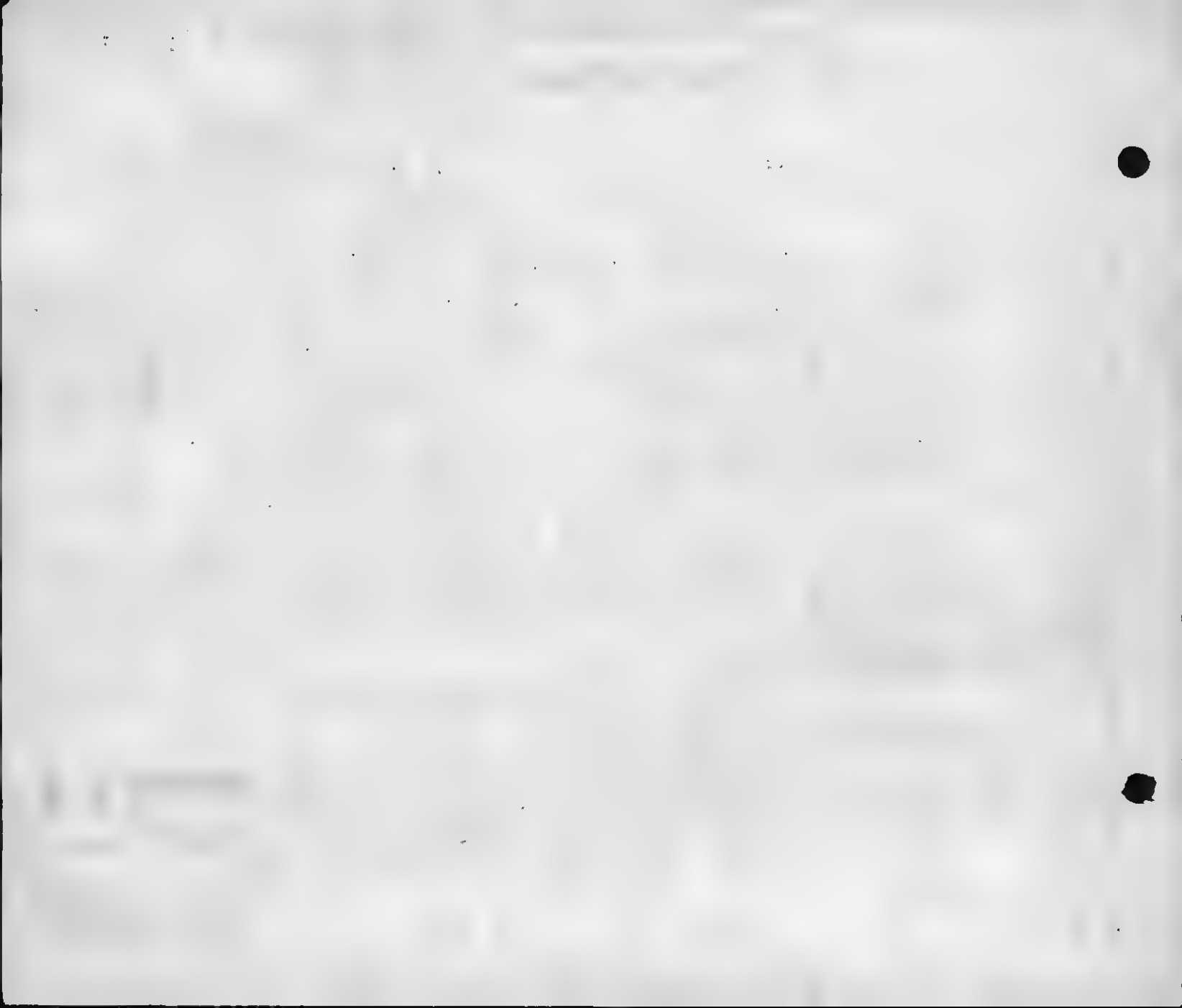
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
24 TOWN <u>HAURE DE GRACE</u>		3 1/2 DAYS		TOWN <u>RURAL Rt = 2</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
71 <u>HARFORD Memorial Hosp.</u>				<u>HAURE DE GRACE</u>		1	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>KATHERINE</u> (Middle) <u>S</u> (Last) <u>LEE</u>				(Month) <u>October</u> (Day) <u>31</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>FEMALE</u>	<u>White</u>	<u>Widowed</u>	<u>1/16/1881</u>	<u>74</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>None</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles Kincaid</u>				<u>Sarah Knight</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>No</u>				<u>Unknown</u>		<u>C Oliver Lee, Haure de Grace, Md</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
153X IMMEDIATE CAUSE				(A) <u>Carcinoma of Sigmoid Colon with</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>metastasis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				(B) <u>Arteriosclerotic Cardiovascular disease</u>			
STATING UNDERLYING CAUSE LAST.				(C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		INTERVAL BETWEEN ONSET AND DEATH	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 1st</u> , 19 <u>55</u> , to <u>Oct 31st</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 31st</u> , 19 <u>55</u> , and that death occurred at <u>1:00</u> M, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Harold Lee</u>				<u>Oct 31st 1955</u>			
M.D. <u>420 North Union Ave. Haure de Grace, Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/2/55</u>		<u>Rock Hill</u>		<u>Level, beyond to Hill</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>11-2-55</u>		<u>A. L. Lewis M.D.</u>		<u>Harold Lee</u>		<u>Haure de Grace, Md</u>	

INSTRUCTIONS

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VS A15C 1-55 10M



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9795				MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		09810	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Reg. Dist. No. 182			
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Harford</u> MARYLAND		STATE <u>V. E</u> COUNTY <u>Robeson</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Rowland</u>		STREET ADDRESS (If rural, give location) <u>Route 1</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bel Air</u>		LENGTH OF STAY (in this place) <u>Transient</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Rowland</u>		STREET ADDRESS (If rural, give location) <u>Route 1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED: (First) <u>Boyd</u> (Middle) <u>Lindsay</u> (Last) <u>Lindsay</u>				4. DATE OF DEATH (Month) <u>October</u> (Day) <u>18</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>April 7 - 1910</u>	
9. AGE last birthday: <u>45</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer</u>		11. BIRTHPLACE (State or foreign country): <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Will Lindsay</u>				14. MOTHER'S MAIDEN NAME: <u>Clara Jackson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>✓</u>				16. SOCIAL SECURITY No.: <u>✓</u>			
17. INFORMANT & ADDRESS: <u>Henry Lindsay Rayhan N.C.</u>				18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
Immediate cause (a) <u>Coronary occlusion</u> DUE TO							
Antecedent cause(s) (b) <u>Hypertension</u> DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		21d. HOW DID INJURY OCCUR?	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Leroy C Palmer</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10/18/55</u>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Oct 24/55</u>		NAME OF CEMETERY OR CREMATORY <u>Rayhan Baptist</u>		LOCATION (City, town, or county) (State) <u>Rowland Robeson Co NC</u>	
DATE REC'D BY LOCAL REG. <u>10-18-55</u>		REGISTRAR'S SIGNATURE <u>Mabella Fourwood</u>		FUNERAL DIRECTOR <u>Joe H. Belam</u>		ADDRESS	

U. S. A.

1917

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9812

## CERTIFICATE OF DEATH

09811  
Reg. Dist. No. 182

## 1. PLACE OF DEATH:

COUNTY HARFORD MARYLAND  
CITY (If outside corporate limits, write RURAL and give nearest town) STREET RD LENGTH OF STAY (In this place) 10 yrs  
OR TOWN STREET RD  
HOSPITAL OR INSTITUTION OR STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY HARFORD  
CITY (If outside corporate limits, write RURAL and give nearest town) RURAL STREET STREET  
OR TOWN STREET  
STREET ADDRESS (If rural give location) STREET

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

FANNIECLIKE

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

10101955

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

FWSINGLE5-12-188570 yrs.

Months

Days

Hours

Min.

## 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

HOUSEWIFEGEN. HLMPYLESVILLE, MDUSA

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

GRAFTON DEUCETheresa THOMPSON

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

NONONEMar. Edward Maxwell, St. J. Ind.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2  
Immediate cause

(a) DUE TO

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c) DUE TO

Chronic BronchitisChronic BronchitisChronic myocarditis

Interval Between Onset And Death

2 yrs.5 yrs6 yrs

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1953 to Oct - 9, 1955, that I last saw the deceased alive on Oct 9, 1955 and that death occurred at 6:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

F.P. Smith, Jr. MDDarlington MD 10/10/55

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION City, town, or county

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

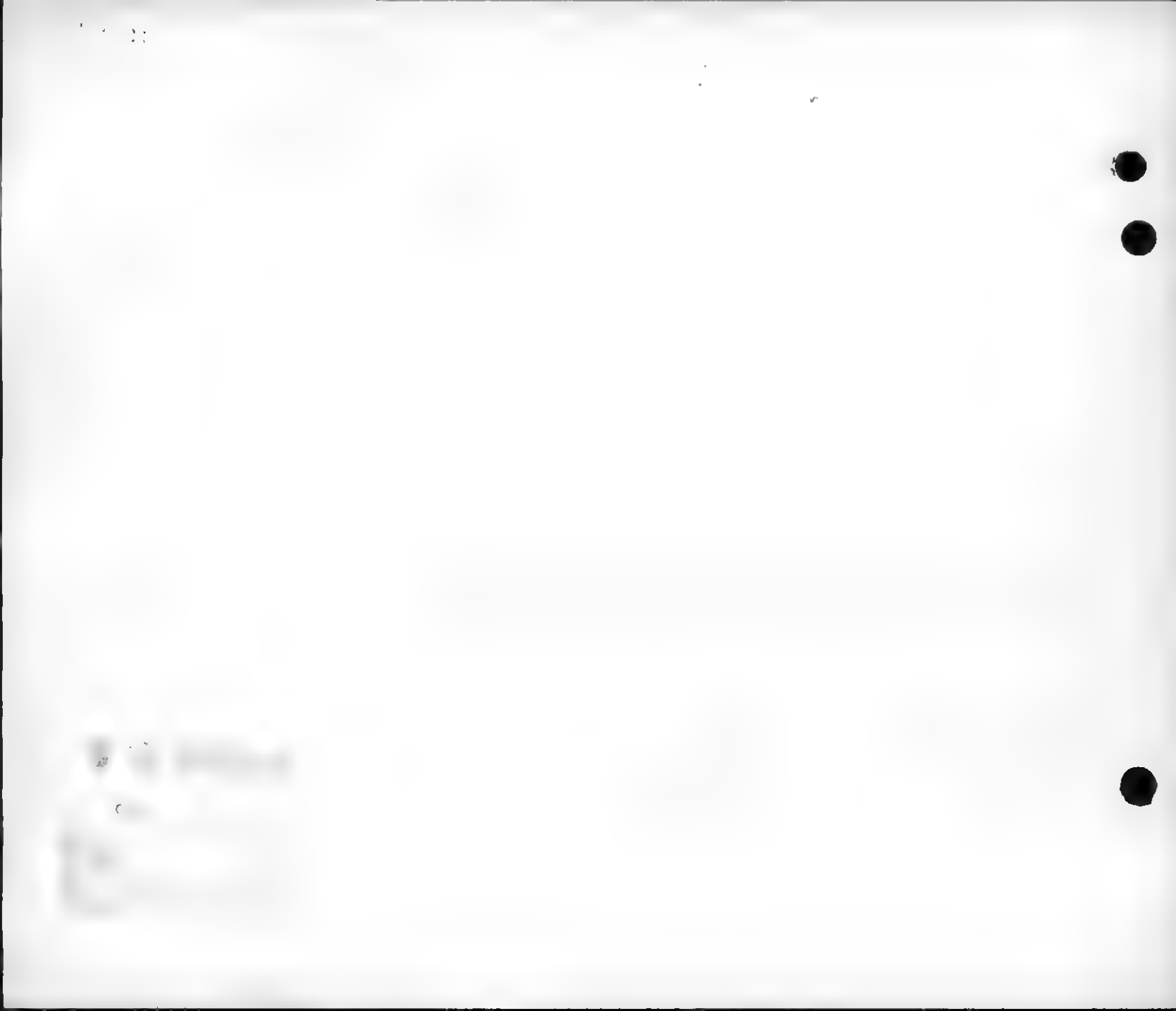
## 24. FUNERAL DIRECTOR

ADDRESS

16-11-55Priscilla HowardW. Howard With Fawn Home Pa

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09812

9813

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Darlington Md</u>		<u>2 weeks</u>		TOWN <u>Whitemarsh</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Walters Convalescent Home</u>				STREET ADDRESS (If rural give location) <u>Rural</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Lapold Lurding</u>				<u>Oct. 26 1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>		<b>9. AGE last birthday</b>	<b>10. IF UNDER 1 YEAR</b> (Months) (Days) (Hours) (Min.)	
<u>Male</u>	<u>White</u>	<u>widower</u>	<u>May 23 1868</u>		<u>87</u> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY</b>	
<u>farmer</u>				<u>Blacksburg Indiana</u>		<u>U.S.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Benjamin Lurding</u>				<u>Anna Bodeman</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>no</u>		<u>none</u>		<u>Mrs Lulu Long</u>			
<b>18. MEDICAL CERTIFICATION</b>							<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>18a. IMMEDIATE CAUSE (A)</b> <u>Cerebral Hemorrhage (second episode)</u>							<u>?</u>
<b>18b. ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>							
<b>(B)</b> <u>Chr, hypertensive cardio-vascular disease</u>							
<b>(C)</b>							
<b>18c. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Oct. 20, 1955</u>, to <u>Oct. 25, 1955</u>, that I last saw the deceased alive on <u>Oct. 25, 1955</u>, and that death occurred at <u>10:28 PM</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
<u>Willard R Hudson M.D.</u>				<u>Forest Hill Md</u>		<u>10/28/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)	
<u>Burial</u>		<u>Oct 29 1955</u>		<u>Mountain Christian</u>		<u>Joppa Md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>10-31-55</u>		<u>Bruce A. Lowwood</u>		<u>W. H. Archer</u>			



1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 9796 CERTIFICATE OF DEATH

09813

Reg. Dist. No. 185

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-75 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Hartford County</u>				STATE <u>Maryland</u> COUNTY <u>Hartford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)				CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harve de Grace</u>				TOWN <u>Edgewood</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>Edgewood Maryland</u>			
<b>3. NAME OF</b> (First) (Middle) (Last) <u>John A. Martin</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>October 9 1955</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>		<b>8. DATE OF BIRTH</b> <u>7/8/1893</u>	
<b>9. AGE last birthday</b> <u>62</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days		<b>11. IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Store Keeper U.S. Govt.</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Govt.</u>			
<b>11. BIRTHPLACE</b> (State or foreign country) <u>W.Da.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Charles D. Martin</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Webb</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>830-27-4756</u>			
<b>17. INFORMANT'S ADDRESS</b> <u>Leona D. Martin Edgewood Md</u>							
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<u>about 6 months</u>	
<b>IMMEDIATE CAUSE (A)</b> <u>Bronchogenic Carcinoma</u>							
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>21b. PLACE (Home, farm, factory, OF INJURY street, office, bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>				<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from</b> <u>Sept. 20th, 1955</u> <b>to</b> <u>Oct 9th, 1955</u> <b>that I last saw the deceased</b> <u>alive on Oct 4th, 1955</u> <b>and that death occurred at</b> <u>6:24 M.</u> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Howard K. Gorman</u>				<b>ADDRESS (Street, city, town, state)</b> <u>M. 420 N. Union Ave. Harve de Grace Md</u>			
<b>DATE</b> <u>Oct 10-1955</u>				<b>DATE SIGNED</b> <u>10/9/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Oct. 12, 1955</u>		<b>(NAME OF CEMETERY OR CREMATORY)</b> <u>Mountain Christian</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Harford Md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
				<u>Howard K. Gorman</u>		<u>Harford Md</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9797

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 09814

No. 181

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Aberdeen</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>Abingdon</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bel Air Ave in front of Post Office</u>				STREET ADDRESS (If rural, give location) <u>Long Bar Harbor</u>			
3. NAME OF DECEASED: (Type or Print) (First) <u>Joseph</u> (Middle) <u>Masek</u> (Last)				4. DATE OF DEATH (Month) <u>October</u> (Day) <u>7</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>April 28 1881</u>	9. AGE last birthday: <u>74</u> yrs.	IF UNDER 1 YEAR: Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>		11. BIRTHPLACE (State or foreign country): <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Joseph Masek</u>				14. MOTHER'S MAIDEN NAME: <u>Hana Rosokhrave</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>218-18-9671</u>		17. INFORMANT & ADDRESS: <u>Hana Masek, Abingdon, Maryland.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY		21c. (City or town) (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Gerald E Palmer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10/7/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>10/10/55</u>		NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		LOCATION (City, town, or county) (State) <u>Aberdeen Maryland</u>	
DATE RECEIVED BY LOCAL REG. <u>October 9-55</u>		REGISTRAR'S SIGNATURE <u>Hellie G. Perry</u>		24. FUNERAL DIRECTOR <u>John G. Yarrington - Aberdeen Md.</u> ADDRESS			





9814

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Gibson MD</u>		<u>30 years</u>		TOWN <u>Gibson</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>John</u> (Middle) <u>T</u> (Last) <u>Monahan SR</u>				(Month) <u>Oct</u> (Day) <u>3</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>White</u>	<u>MARRIED</u>	<u>July 4 - 1875</u>	<u>22</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Artist</u>		<u>Carpenter</u>		<u>Upper Cross Rds</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John T Monahan</u>				<u>Mary Cain</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, of unk.)		16. SOCIAL SECURITY NO		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>216-10-7494</u>		<u>Mrs John T Monahan Sr Fennell St Md</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>422.1</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				<u>36 hr</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>				<u>5 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Myocarditis</u>				<u>5 yrs</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 15 1955</u> to <u>Oct 3 1955</u> , that I last saw the deceased alive on <u>Oct 1st 1955</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>F P Smolyarsky</u> M.D.				DATE SIGNED <u>Oct 3-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct 5 1955</u>		<u>St Ignatius</u>		<u>Hickory MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>10-3-55</u>		<u>Priscilla Lowwood</u>		<u>Joseph J. F. Bel Air Md</u>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9798

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09816  
Reg. Dist.

No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>***</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Harford</u>	<u>10 minutes</u>	TOWN <u>Baltimore</u>	<u>3101-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>708 W. Fairmount Avenue</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Judolph</u>	(Middle) <u>J.</u>	(Last) <u>Moore</u>	(Month) <u>October</u> (Day) <u>7</u> (Year) <u>1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Unknown</u>	8. DATE OF BIRTH: <u>Unknown</u>
9. AGE last birthday: <u>Approx. 30 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	
		<u>Unknown</u>	
11. BIRTHPLACE (State or foreign country): <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Unknown</u>		<u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
		17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) ..... <u>Coronary occlusion</u> DUE TO			
Antecedent cause(s) (b) ..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10/8/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>REMOVAL</u>	DATE THEREOF <u>OCT 12 1955</u>	NAME OF CEMETERY OR CREMATORY <u>UNION MEDICAL SCHOOL</u>	LOCATION (City, town, or county) (State) <u>29 S GREEN ST</u>
DATE REC'D BY LOCAL REG. <u>Oct. 24, 1955</u>	REGISTRAR'S SIGNATURE <u>Dr. J. L. Lewis</u>	24. FUNERAL DIRECTOR <u>Duffel Bldg 1800 E 10th BARB ST</u>	



1

INSTRUCTIONS

**1** **TO ATTEND PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-58

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

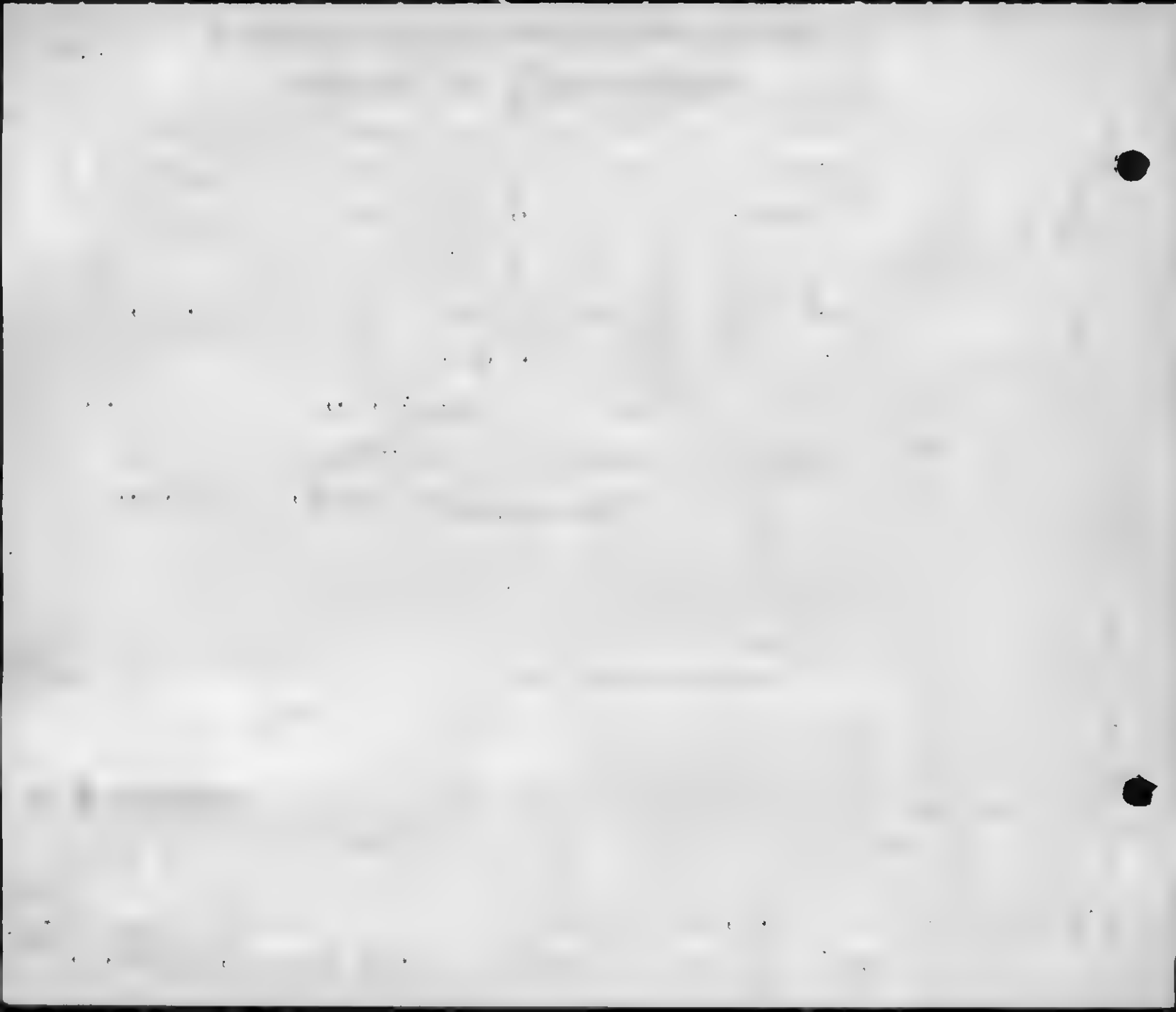
09817

9815

## CERTIFICATE OF DEATH

Reg. Dist. No. 180

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Harford</b>		STATE <b>MARYLAND</b>		STATE <b>Maryland</b>		COUNTY <b>Harford</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Abingdon</b>		<b>23 yrs.</b>		TOWN <b>Abingdon</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<b>Emily Frances Morkosky</b>				<b>Oct. 13, 19 55</b>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<b>female</b>	<b>white</b>	<b>married</b>	<b>Mar. 27, 1917</b>	<b>38</b> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>Housewife</b>		<b>none</b>		<b>Baltimore, Md.,</b>		<b>U.S.A.</b>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>James Chovjan</b>				<b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<b>no</b>		<b>none</b>		<b>Bohus Morkosky, Abingdon, Md.,</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>002X IMMEDIATE CAUSE (A)</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>						<b>6 yrs</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>						<b>Tuberculosis For advanced</b>	
<b>STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>						<b>Pulmonary with cavitation</b>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 7-21, 1949, to 10-13, 1955, that I last saw the deceased alive on 10-13, 1955, and that death occurred at 4 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>			
<b>Edw E. Hodous</b>				<b>Edgewood Md 10-14-55</b>			
<b>DATE</b>				<b>DATE SIGNED</b>			
<b>Oct 15, 1955</b>				<b>10-14-55</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<b>Burial</b>		<b>Oct. 17, 1955</b>		<b>Holy Redeemer</b>		<b>Baltimore Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<b>DATE</b>		<b>Norma S. Moore</b>		<b>Howard K. McComas &amp; Son, Abingdon, Md.</b>			



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INSTRUCTIONS

1

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 9799 CERTIFICATE OF DEATH

09818

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
24 TOWN <i>Harford Grace</i>		8 days		24 TOWN <i>Harford Grace</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
7. <i>Harford Memorial</i>				397 Wilson St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last)							
<i>Elizabeth Osburne</i>				<i>October 13 1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>female</i>	<i>C.</i>	<i>Widowed</i>	<i>11/8/1886</i>	<i>69</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>		<i>None</i>		<i>Carlyle, Pa.</i>		<i>USA.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Henry McFarland</i>				<i>UNKNOWN Harford Grace</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<i>no</i>				<i>UNKNOWN</i>		<i>Philip Fickens</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Uremia.</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertensive C-V. Disease</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Diabetes Mellitus. Syphilis.</i>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>October 5, 1955</i> , to <i>October 13, 1955</i> , that I last saw the deceased alive on <i>Oct 12</i> , 1955, and that death occurred at <i>7:45</i> A.M. from the causes and on the date stated above.							
SIGNATURE <i>A. Sandeeki M.D.</i>				ADDRESS (Street, city, town, state) <i>15 Courtland St. BEL AIR Md</i>		DATE SIGNED <i>10.14.55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>BURIAL</i>		<i>10/15/55</i>		<i>MT CALVARY</i>		<i>Abertown, Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>Oct. 15 - 1955</i>		<i>G. L. Lewis M.D.</i>		<i>Funerary Home, Inc., 1000 E. Green, Md.</i>			





1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09819

9816

## CERTIFICATE OF DEATH

Reg. Dist. No. 18.1

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Hartford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>X Aberdeen</u>				TOWN <u>Aberdeen Rural #1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural #1 near Perryman.</u>				STREET ADDRESS (If rural give location) <u>near Perryman.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Blaetie</u>		(Middle) <u>Nelson</u>		(Last) <u>Richardson</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>May 21st. 1867</u>	
9. AGE last birthday <u>88</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wif.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George N. Nelson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Ann Gallup</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Geo. Willard Richardson Aberdeen R. #1. Md.</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>4.2.2.2</u>							
IMMEDIATE CAUSE (A) <u>Chronic Myocardial Degeneration</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 11, 1955</u> to <u>Oct 12, 1955</u> , that I last saw the deceased alive on <u>Oct 12, 1955</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Howard A. Hallenay M.D. Perryman, Md.</u>				DATE SIGNED <u>Oct 13, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/15/55</u>		NAME OF CEMETERY OR CREMATORY <u>Spesutia Cemetery</u>		LOCATION (City, town, or county) (State) <u>Perryman Md.</u>	
24. REC'D BY REGISTRAR <u>Mellie R. Perry</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Darring</u>		ADDRESS <u>Aberdeen Md.</u>	
DATE <u>Oct 14-55</u>							

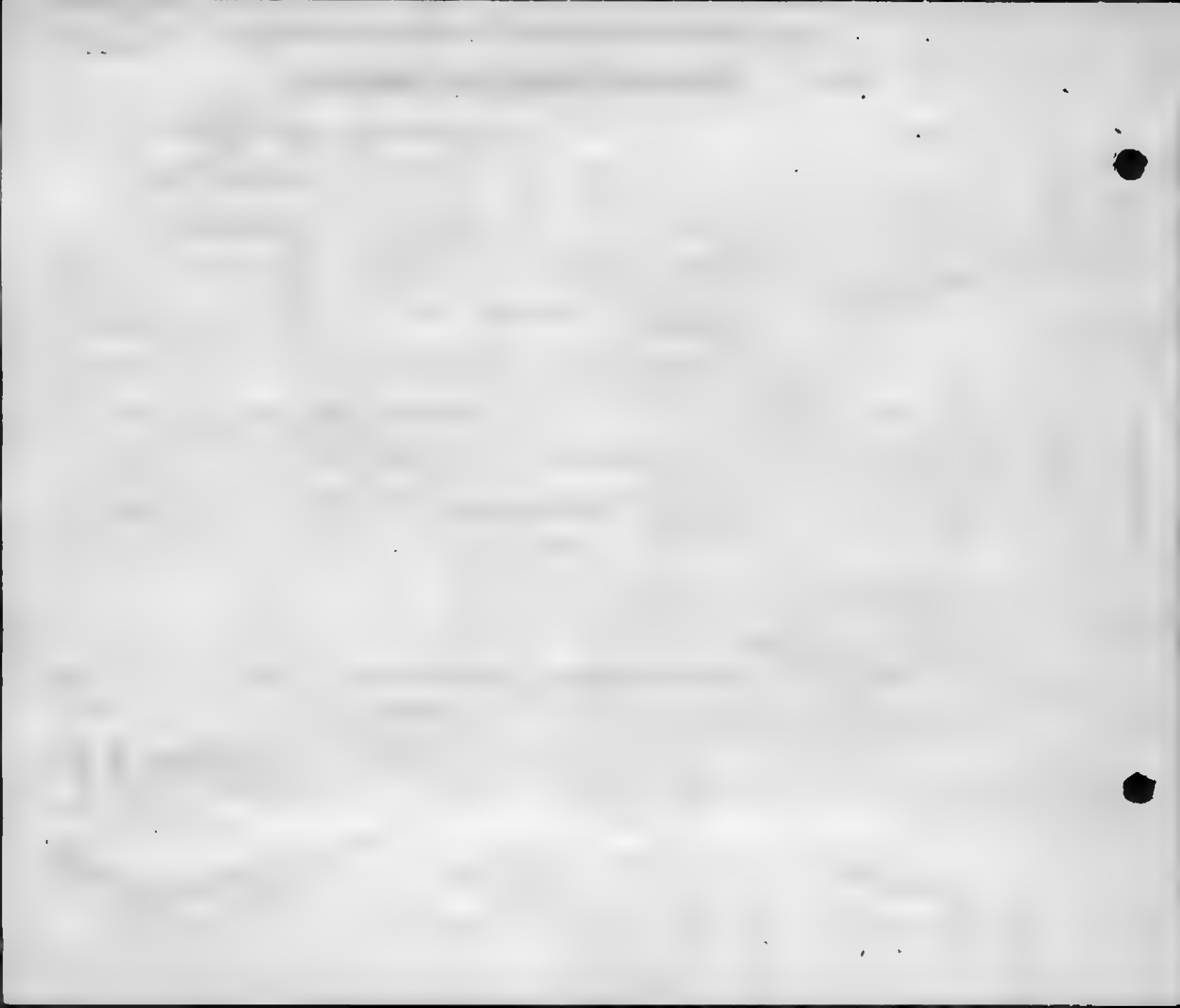
INSTRUCTIONS

1

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

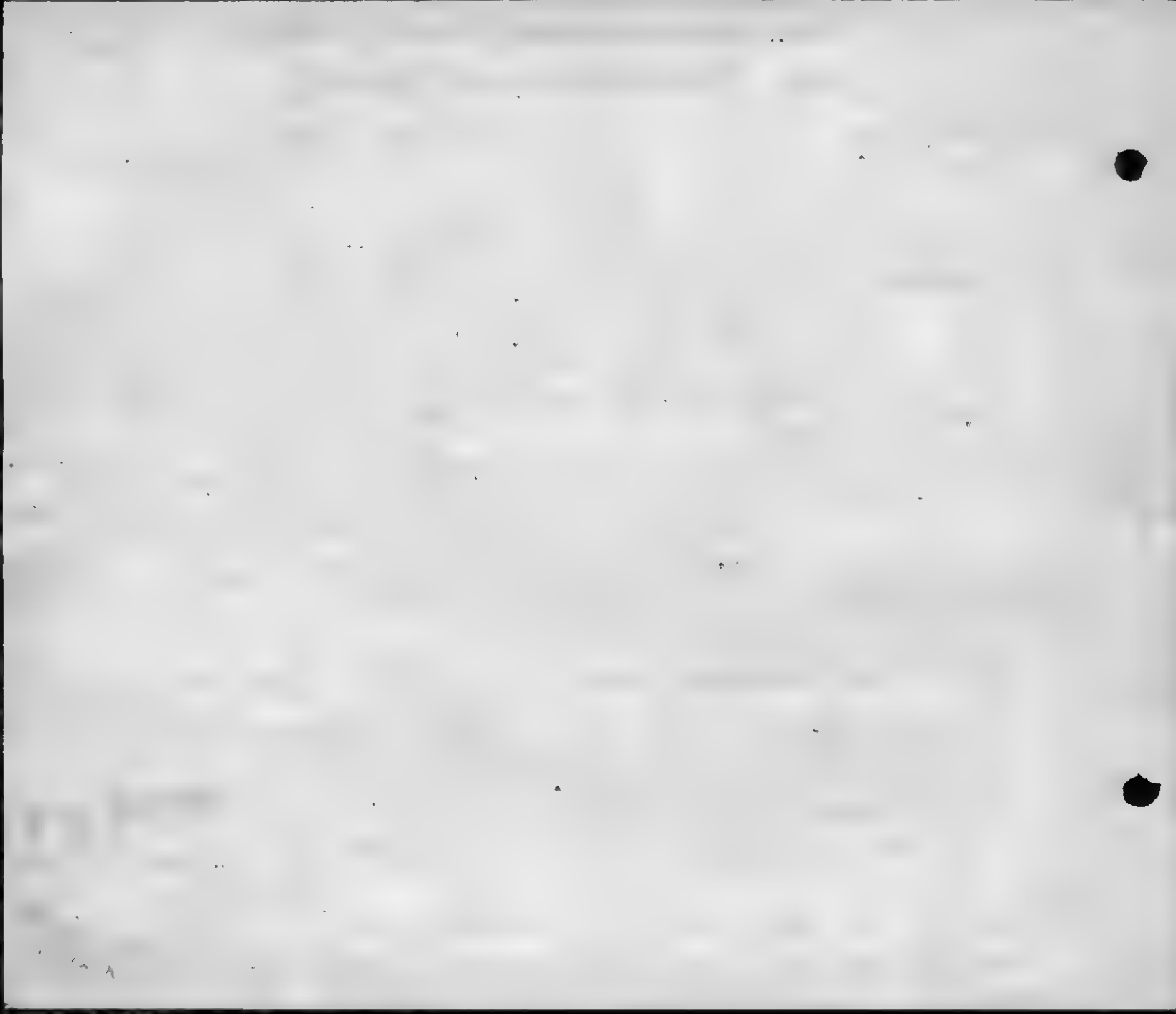
## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09820

## 9817 CERTIFICATE OF DEATH

Reg. Dist. No. .... 182

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Benson</u> TOWN <u>6 years</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Whittaker Mill Rd</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Benson</u> TOWN <u>6 years</u> STREET ADDRESS <u>Whittaker Mill Rd</u> (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Magdalena</u> (First) <u>SCHUMM</u> (Last)		4. DATE OF DEATH <u>OCT. 6</u> (Month) <u>1955</u> (Year)	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Oct 4.13.1863</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Balt. more, Md</u>
13. FATHER'S NAME <u>Louis Knoll</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hoffman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS <u>Katherine Hesse, 833 E. Belve</u>		18. INTERVAL BETWEEN DEATH AND DEATH CERTIFICATE <u>24 Hrs</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
904. IMMEDIATE CAUSE (A) <u>Congestive C-V Failure with Edema</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Fracture of Left Hip, not healed</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Old age (92)</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>May 10, 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Fracture of Neck of Left Humerus</u>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>—</u>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Benson, Harford, Maryland</u>	
21c. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>May 4, 1955 5 PM</u>		21d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
22. I hereby certify that I attended the deceased from <u>Sept 29, 1955</u> , to <u>Oct 6, 1955</u> , that I last saw the deceased alive on <u>Oct 1st, 1955</u> and that death occurred at <u>9:40 AM</u> from the causes and on the date stated above.		23. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Benson, Harford, Maryland</u>	
24. REC'D BY REGISTRAR <u>Lucille Forward</u> REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>401 S. CONKLE NO 6 ST, BALTO, 24, MD.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>10-10-55</u>	
NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM</u>		LOCATION (City, town, or county) (State) <u>7401 GERMAN HILL RD, MD.</u>	



9818

09821  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 181

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Harford</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
<input checked="" type="checkbox"/> TOWN <u>Aberdeen Rural.</u>	<u>approx 2 days.</u>	TOWN <u>Harrods Grace Rural.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bush River Penna RR Sta.</u>		STREET ADDRESS (If rural, give location) <u>Webster</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Christian</u>	(Middle) <u>Peter</u>	(Last) <u>Smith</u>	(Month) <u>October</u> (Day) <u>2</u> (Year) <u>1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Dec 5 - 1903</u>
9. AGE last birthday: <u>51</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Contracting business</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Garage</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>John H. Smith</u>		14. MOTHER'S MAIDEN NAME: <u>Matilda Bodt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No.: <u>216-07-6681</u>	
17. INFORMANT & ADDRESS: <u>O.L. Parson, Harrods Grace Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
(a) Immediate cause <u>Fracture Cervical Vertebra</u>		
(b) Antecedent cause(s) <u>974X</u>		
(c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		

11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home R.R. tracks</u>	21c. (City or town) (County) (State) <u>Aberdeen Harford Md.</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Sept 30 '55 9 P.M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Threw self from Bridge</u>

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE Harold P Palmer CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 10/2/55  
DEPUTY MEDICAL EXAMINER ☐ M.D. ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>Oct 5 - 1955</u>	NAME OF CEMETERY OR CREMATORY: <u>St. Paul Lutheran Cemetery</u>	LOCATION (City, town, or county) (State): <u>Aberdeen Maryland</u>
DATE REC'D BY LOCAL REG. <u>Oct 4 - 1955</u>	REGISTRAR'S SIGNATURE: <u>Willie G. Perry</u>	24. FUNERAL DIRECTOR: <u>John G. Farrington</u>	ADDRESS: <u>Aberdeen Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

100  
100

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9870

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

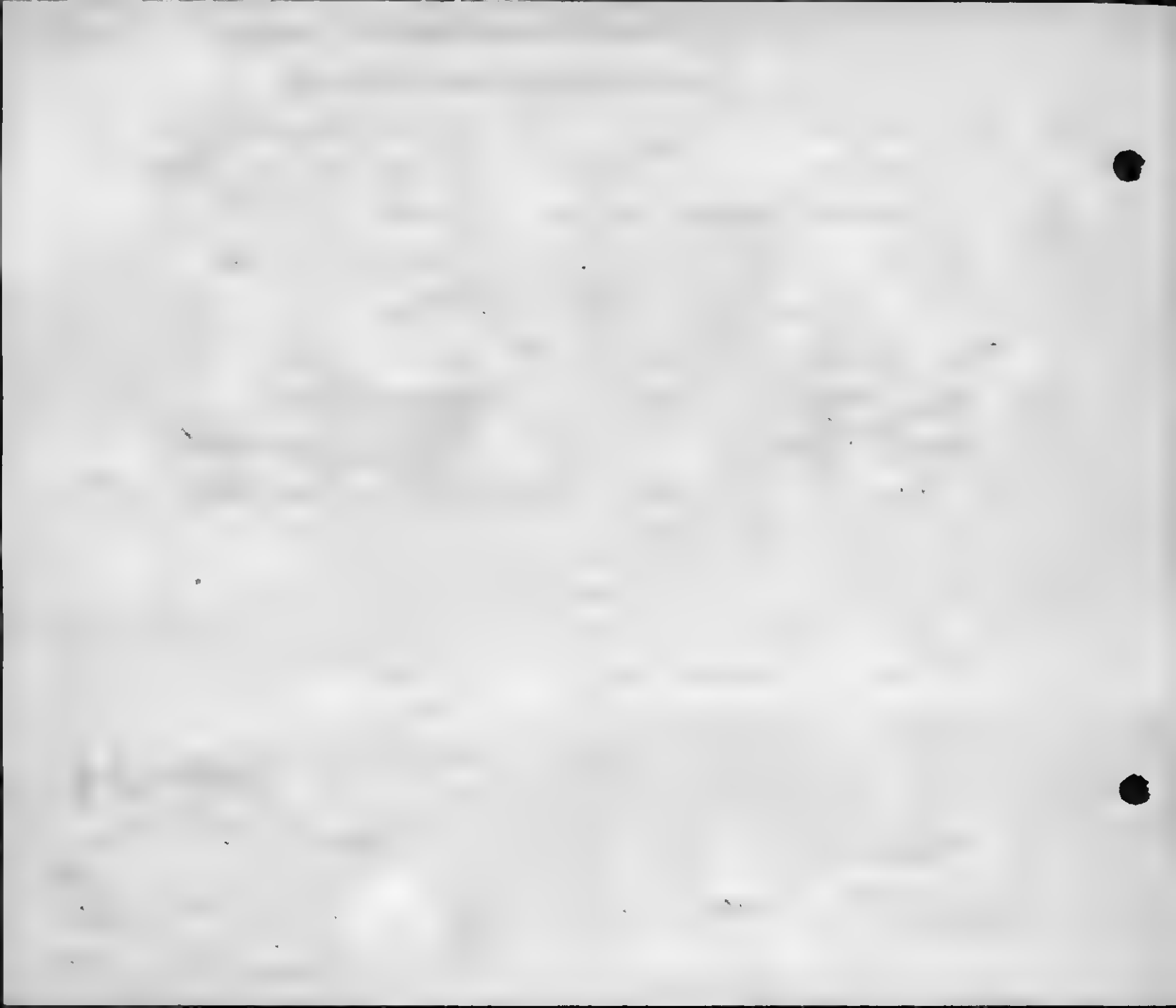
INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VE AISC 1-55 10M

1. PLACE OF DEATH COUNTY <u>Harford</u> STATE <u>Maryland</u> CITY OR TOWN <u>Harford</u> (If outside corporate limits, write RURAL and give nearest town) HOSPITAL OR INSTITUTION OR STREET ADDRESS _____		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY OR TOWN <u>Harford</u> (If outside corporate limits, write RURAL and give nearest town) STREET ADDRESS <u>226 D. Union Ave.</u> (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Beulah</u> <u>Lyon</u> <u>Spencer</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10/7/55</u> 19 <u>55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>3/11/1875</u>
9. AGE last birthday <u>80</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
11. USUAL OCCUPATION (Give kind of work depending most of working life, even if retired) <u>House Wife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Geo. L. Lyon</u>		14. MOTHER'S MAIDEN NAME <u>Maria Cunningham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS <u>Thomas Lyon, Harford, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>cardio-vascular disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH _____	
19. DATE OF OPERATION <u>Oct 7</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 2</u> , 19 <u>50</u> , to <u>Oct 7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 7</u> , 19 <u>55</u> , and that death occurred at _____ M., from the causes and on the date stated above.			
SIGNATURE <u>A. L. Lewis, M.D.</u>		DATE SIGNED <u>10/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>10/10/55</u>	NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>	LOCATION (City, town, or county) (State) <u>Harford, Md.</u>
24. REC'D BY REGISTRAR DATE <u>Oct. 10-55</u>	REGISTRAR'S SIGNATURE <u>A. L. Lewis, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Lyon</u> ADDRESS <u>Harford, Md.</u>	





9819

09823

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 180

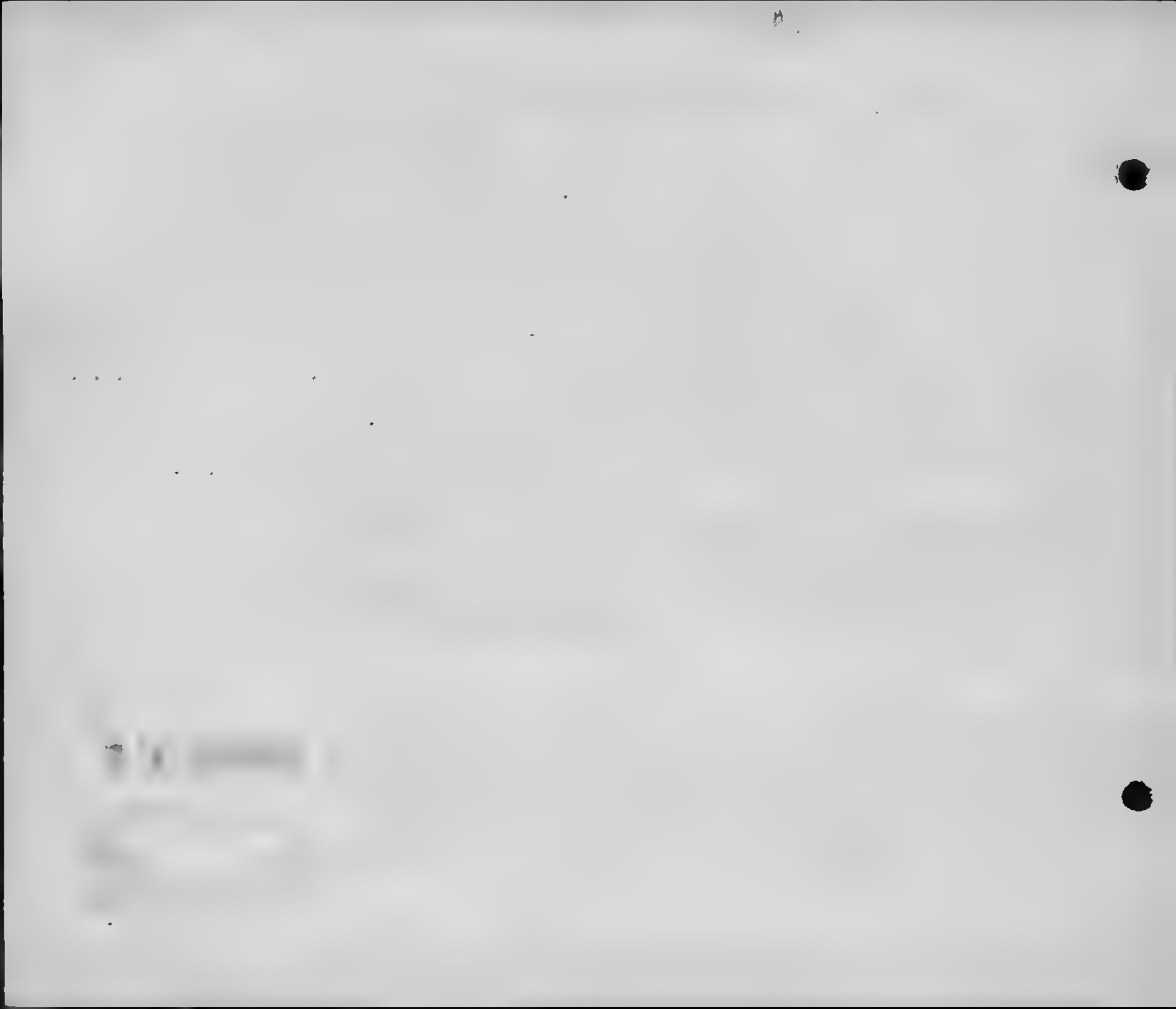
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Harford	MARYLAND	STATE	Maryland	COUNTY Harford
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Abingdon	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN	Abingdon	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location)				
3. NAME OF DECEASED: (Type or Print)			4. DATE OF DEATH		
(First) Audrey (Middle) E (Last) Thomas			(Month) October (Day) 17 (Year) 1955		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
female	white	married	Apr. 15, 1920	35 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Comptometer Operator		Automobile		Baltimore, Md.	
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
Charles Keys			Mary L. Seifert		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
no		?		Edward W. Thomas, Abingdon, Md.	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
976X Immediate cause (a) Gunshot wound cerebrum					
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause					
stating underlying cause last (c)					
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)	
		Home		Abingdon Harford Md.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
October 17, 1955 15.				Shot self with pistol	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		M. D.		DATE SIGNED	
Heald C Palmer				10/17/55	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		LOCATION (City, town, or county) (State)	
Burial		Oct. 21, 1955		Joppa, Harford, Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
Oct 22, 1955		Norma H. Moore		Howard K. McComas & Son, Abingdon, Md.	

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9871

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harre-de-Grace</u>		<u>12 days</u>		TOWN <u>Aberdeen</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>50 Raymond Ave</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Eva M Toner</u>				<u>10 16 1955</u>			
5. SEX	6. CO. OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH		9. AGE (last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>Female</u>	<u>white</u>	<u>married</u>	<u>Oct. 29 1895</u>		<u>56</u> yrs.	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
<u>House-wife</u>					<u>Maryland</u>		
13. FATHER'S NAME				14. MOTHER'S MARDEN NAME			
<u>Felix Jawonsky</u>				<u>Mary ? Kruger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
						<u>Richard J. Toner, Husband</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>16 dx</u>				<u>Cordian decompensation</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Bronchogenic carcinoma</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-7</u> 19 <u>53</u> to <u>10-16</u> 19 <u>55</u> , that I last saw the deceased alive on <u>10-16</u> 19 <u>55</u> , and that death occurred at <u>4:55 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>E. J. Semin</u>				ADDRESS (Street, city, town, state) <u>Harre-de-Grace, Md.</u>		DATE SIGNED <u>Oct. 16 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 19, 1955</u>		<u>Beth Ann Memorial Garden</u>		<u>Beth Ann</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Oct. 19-1955</u>		<u>A. L. Lewis</u>		<u>John S. Tarning</u>		<u>Aberdeen Md</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS MHC 1-58 10M

U. S.

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10913

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:

COUNTY **Harford** MARYLAND  
CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) (in this place)  
TOWN **Abingdon**

HOSPITAL OR INSTITUTION OR STREET ADDRESS **McComas Funeral Home**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **U** COUNTY  
CITY (If outside corporate limits write RURAL and give nearest town) OR  
TOWN **K**

STREET ADDRESS **N** (If rural, give location)  
**O**

3. NAME OF DECEASED:  
(Type or Print)

(First) (Middle) (Last)  
**Unidentified (John Doe)**

4. DATE OF DEATH (Month) (Day) (Year)  
**N** **10** **15** **1955**

6. SEX:

**Male**

6. COLOR OR RACE:  
**Colored**

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):  
**U**

8. DATE OF BIRTH:

**U**

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.  
yrs. Months Days Hours Min.  
**50?** **U**

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:  
**K**

11. BIRTHPLACE (State or foreign country):  
**N**

12. CITIZEN OF WHAT COUNTRY?  
**K**

13. FATHER'S NAME:

**N**

14. MOTHER'S MAIDEN NAME:

**N**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:  
**N**

17. INFORMANT & ADDRESS:  
**N**

**N**

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

**9.29.8**  
Immediate cause

(a) **Drowning**

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY **River**

21c. (City or town) (County) (State)  
**Bush River in Harford County, Maryland**

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY **10/15/55 10 A. M.**

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?  
**Presumably drowned, accidentally.**

22. I hereby certify that I took charge of the remains described above, held an **Autopsy** ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

**William V. Smith**

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED  
DEPUTY MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAM. **11/18/55**

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

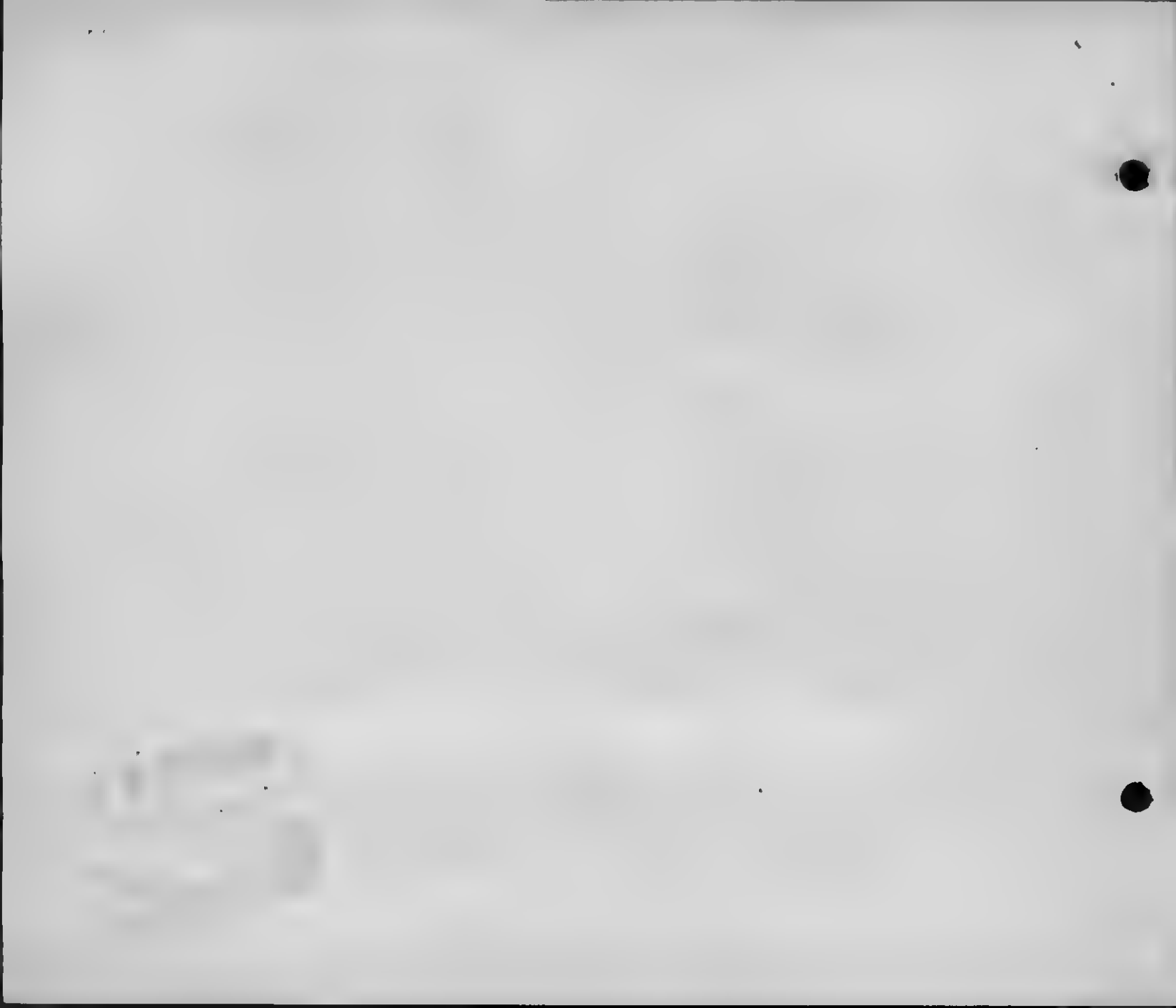
**Nov. 23, 1955** **H. H. Redmill**

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9802

## CERTIFICATE OF DEATH

09825

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Md.</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
24 TOWN <u>Harre-de-Grace</u>		12 days		TOWN <u>Harre-de-Grace</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
71 <u>Harford Memorial Hospital</u>				<u>RD # 1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>OTHEL Elizabeth Washington</u>				(Month) (Day) (Year) <u>10-1-1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>Colored</u>	<u>Married</u>	<u>3-19-1893</u>	<u>62</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Domestic work</u>		<u>Private Family</u>		<u>Md.</u>		<u>U.S.A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Samuel B. Kehly</u>				<u>Mary Elizabeth Banks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>No</u>						<u>Edward Washington</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
334 X IMMEDIATE CAUSE (A)				<u>Pulmonary Edema - Uremia</u>			
ANTECEDENT CAUSE(S) DUE TO (B)				<u>Hemiplegia left -</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>Arteriosclerosis - Hypertension</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>1 day -</u>			
				<u>12 days -</u>			
				<u>10 years -</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 20, 1955</u> to <u>Oct 1, 1955</u> , that I last saw the deceased alive on <u>Oct 1, 1955</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Anna Walbert MD</u> M.D.				<u>Harre-de-Grace Md</u>		<u>Oct 1, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Burial</u>	<u>10-5-55</u>	<u>Asbury Cemetery</u>		<u>Churchville, Md.</u>			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		
<u>Oct 3, 1955</u>	<u>A. L. Lewis M.D.</u>		<u>Otelia J. Bullard</u>		<u>Harre-de-Grace, Md.</u>		





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09826

9813

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 HAVRE DE GRACE</u>		LENGTH OF STAY (In this place) <u>3 DAYS</u>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 HAVRE DE GRACE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 840 ONTARIO ST.</u>				STREET ADDRESS (If rural give location) <u>840 ONTARIO ST.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARY</u> (Middle) <u>HOBGOOD</u> (Last) <u>WILLIAM</u>				(Month) <u>OCT.</u> (Day) <u>4</u> (Year) <u>1955</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>DIVORCED</u>	8. DATE OF BIRTH <u>Sept. 17, 1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK (RETIRED) U.S. F.A.B.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>N.C.</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>WM. HENRY HOBGOOD</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA SANDERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>215-07-8633</u>		17. INFORMANT & ADDRESS <u>Wm. STERLING P. WILLIAM</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION <u>HAVRE DE GRACE, MD.</u>			
157X IMMEDIATE CAUSE (A) <u>Cardiac Insufficiency - Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Suspected Carcinoma of pancreas</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 30, 1955</u> , to <u>Oct 4, 1955</u> , that I last saw the deceased alive on <u>Oct 4, 1955</u> , and that death occurred at <u>11:14</u> M., from the causes and on the date stated above.							
SIGNATURE <u>A. L. Lewis</u>		M.D.		ADDRESS (Street, city, town, state) <u>Havre de Grace, MD.</u>		DATE SIGNED <u>10/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>OCT. 6 1955</u>	NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>		LOCATION (City, town, or county) <u>HAVRE DE GRACE, MD.</u>			
24. RECEIVED BY REGISTRAR <u>DATE Oct. 5-1955</u>	REGISTRAR'S SIGNATURE <u>A. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P. Madison Mitchell</u>		ADDRESS <u>Havre de Grace, MD.</u>		

## 5124

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INSTRUCTIONS

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VS 415C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9874

## CERTIFICATE OF DEATH

09827

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
31 TOWN <u>ABERDEEN</u>		<u>LIFE</u>		31 TOWN <u>ABERDEEN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>118 N. PHILADELPHIA, RD.</u>				<u>118 N. PHILADELPHIA, RD.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>GEORGE MITCHELL WORTHINGTON</u>				(Month) (Day) (Year) <u>Oct. 1 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>MAR. 2, 1882</u>	<u>73</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>FIREMAN</u>		<u>A.P.G.</u>		<u>MD.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JOHN WORTHINGTON</u>				<u>SARAH NELSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>MRS. LOTTIE MAGRAW WORTHINGTON</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE(S) DUE TO				<u>Cerebral Hemorrhage</u>		<u>5 Wk</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>Arterial Hypertension</u>		<u>5 yr</u>	
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY Occurred While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-1-55</u> , 19 <u>55</u> , to <u>10-1-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-1-55</u> , 19 <u>55</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. P. W. W.</u>				ADDRESS (Street, city, town, state) <u>Aberdeen, Md.</u>		DATE SIGNED <u>10-3-55</u>	
23. BURIAL, CREMATION REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>OCT. 4 1955</u>		<u>ANGEL HILL CEM.</u>		<u>HAYRE DE GRACE, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Oct 3-55</u>		<u>Mellie G Perry</u>		<u>R. Madison Mitchell</u>		<u>Hayre de Grace, Md.</u>	

CERTIFICATE OF DEATH

1900

Page No. 10

NAME OF DECEASED

JOHN W. WILKINSON

AGE

40

SEX

MALE

DATE OF DEATH

12-15-1900

12-15-1900

PLACE OF DEATH

HOME

12-15-1900

12-15-1900

12-15-1900

12-15-1900

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